PRINTED: 06/13/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES TO A DECIVIDED (STIDDITED /CLIA		The result is a consensulation.			OMB NO. 0938-0391		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPI	LETED
		155760				05/13/2	2011
			B. WIN		A DODDEGG CHTV, CTATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	VATERFORD CIRCLE		
MAPLES	AT WATERFORD (CROSSING HEALTH CAMPUS		GOSHE	EN, IN46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
F0000							
1 0000							
	This visit was fo	or a Recertification and	FO	0000	This Plan of Correction		1
			10	7000	constitutes the written allega	ation	
	State Licensure S	Survey.			of compliance for the deficie		
					cited. However, submission		
	Survey dates: M	Iay 9, 10, 11, 12 and 13,			this Plan of Correction is no		
	2011				admission that a deficiency	exists	
					or that one was cited correc		
	Facility manual	011150			This Plan of Correction is		
	Facility number:				submitted to meet requirement		
	Provider number				established by state and fed		
	AIM number:	200831020		law.The Maples at Waterfo			
					Crossing Health Campus de		
	Survey team:				this Plan of Correction to be		
	Mavis Stob, RN	TC			considered the facility's Alle		
					of Compliance. Compliance		
	Carol Miller, RN				effective on June 12, 2011T		
	Honey Kuhn, RN	V			Maples at Waterford Crossii Health Campus respectfully	-	
					requests this Plan of Correct		
	Census bed type	:			be submitted as desk review		
	SNF/NF: 17				compliance for the deficience		
	SNF: 36				cited.		
	Total: 53	3					
	Census payor typ	pe:					
	Medicare:	13					
		17					
	Other: 23 Total: 53 Sample: 14						
	_						1
	These deficiencies also reflect state						
							1
		accordance with 410 IAC					1
	16.2.						
	I		1		I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

PERU11

Facility ID:

011150

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 05/13/2011
NAME OF PROVIDER OR SUPPLIE	CROSSING HEALTH CAMPUS	1332 W	ADDRESS, CITY, STATE, ZIP CODE /ATERFORD CIRCLE EN, IN46526	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Quality review Jennie Bartelt, I	completed 5/19/11 by RN.			
assessment to de resident's compresident's compresident's compresident's must care plan for each measurable objet a resident's medit psychosocial necomprehensive at the care plan must are to be furnisher resident's highest mental, and psychological necomprehensive at the care plan must be furnisher esident's highest mental, and psychological under § would otherwise but are not provide exercise of rights right to refuse the Based on record facility failed to regard to pacem.	ust describe the services that ed to attain or maintain the t practicable physical, chosocial well-being as 483.25; and any services that be required under §483.25 ded due to the resident's under §483.10, including the eatment under §483.10(b)(4). If review and interview, the eassure a care plan in taker use was revised for 1 th a pacemaker in a Resident #36)	F0279	It is the expectation of this fato use the results of the assessment, to develop, reviand revise the resident's comprehensive plan of care. corrective action will be done the facility?Resident #36 Parmaker care plan was revised Physician order was received notifity physician if heart rate	What e by ce

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Event ID:

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011150 If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155760				ULTIPLE CON LDING	nstruction 00	(X3) DATE S	ETED
		155760	B. WIN	IG		05/13/2	011
	PROVIDER OR SUPPLIEF	CROSSING HEALTH CAMPUS	•	1332 W	DDRESS, CITY, STATE, ZIP CODE ATERFORD CIRCLE N, IN46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	indicated diagnowere not limited coronary artery of insertion and was a service of the particle of the particl	on the daily vital signs inths of April and May the resident's pulse rate to 118 beats per minute. The plan to indicate what eters would warrant			120. Care plan was iniciated include notification orders. He will the facility identify other residents having the potential be effected by the same pract and what corrective action witaken? An audit of resident che with identified pacemakers have a plan of care written an implemented to address the pacemaker at time of admission. How will corrective action be ensured to be with pacemakers will audit all new admissions and those reside found to be with pacemakers have a plan of care written an implemented to address the pacemaker at time of admission. How will corrective action be monitored to ensure deficit practice does not recure what QA will be put into place? Residents admitted with pacemakers will have their medical chart audited within first seventy-two (72) hours of admission, and quarterly, by Director of Health Services, of designee, to assure that compliance with care plan requirements are met. To beginned in the pacemaker will be ongoing. The DHS will report monthly to the Quality Assura Committee on outcomes of the audits for the next 6 months, thereafter as determined by the pacemaker and	ow If to obtice ill be narts as ill be or of the or on the or of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760		A. BUII B. WIN	LDING	00	(X3) DATE S COMPL 05/13/2	ETED	
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS		STREET A	ADDRESS, CITY, STATE, ZIP CODE VATERFORD CIRCLE EN, IN46526		
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F0333 SS=D	free of any signific Based on int	nsure that residents are ant medication errors. erviews and record acility failed to	F0	333	Quality Assurance Committe The DHS is responsible for substantial compliance. By a date the systemic changes w completed: June 12, 2011 It is the expectation of this fa to ensure that residents are for of any significant medication.	what vill be cility free	06/12/2011
	follow the plane regard to admedication to medications twice. This in a signification that affire residents who were reviewed 14 (Resident	hysician's order in ministration of o assure were not given deficiency resulted ant medication fected 1 of 14 ose medications ed in a sample of t # 29).			errors.What corrective action be accomplished for those residents found to have beer effected by the deficient practice:Following medicatio error for resident #29 the physician and family were notified. Physician order was received to monitor blood pressure and pulse every ho and notify physician for blood pressure reading of anything than 90 systolic, and 60 dias No ill effects were noted duri the assessment, and blood pressure remained above 90 systolic and 60 diastolic.How other residents having the potential to be affected by the	n ur d less tolic. ng	
	policy for M Administrati Procedural C received on :	most current edication			same deficient practice will be identified and what corrective action will be taken: An audit resident medication records found no defcit practices, no other residents were identified. What measures will put into place or what system changes will be made to ense that the deficient practice do not recur: Facility reviewed its policy and found it to be sufficient. Licensed staff were	e of ll be nic ure es s	

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN46526 (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED COMPLETED O5/13/2011		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPLI	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS INCLUDING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL. TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL. TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DECED MUST	AND LEAN	or correction		1				
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (XA) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY PULL) (EACH DEFICIENCY MUST BE PERCEDED BY PULL) (EACH DEFICIENCY MUST BE PERCEDED BY PULL) (REACH DEFICIENCY MUST BE PERCEDED BY PULL) (REGULATORY OR LSC (IDENTIFYING INFORMATION)) Review of the policy indicated, "Purpose: to provide guidelines for the times of medication administration. Procedure: 1Trilogy Health Services honors the resident's right to self determine their schedule and care choices and to maintain an environment and routine similar to their pattern prior to residing at the campus. 2. Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD - (every day) after the resident awakens in the morning (morning is designated as times between 4 AM and 10 AM)	NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A			
Review of the policy indicated, "Purpose: to provide guidelines for the times of medication administration. Procedure: 1Trilogy Health Services honors the resident's right to self determine their schedule and care choices and to maintain an environment and routine similar to their pattern prior to residing at the campus. 2. Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD - (every day) after the resident awakens in the morning (morning is designated as times between 4 AM and 10 AM) PREFIX TAG PREVIX TAG PREVI	MAPLES	AT WATERFORD O	CROSSING HEALTH CAMPUS		1			
"Purpose: to provide guidelines for the times of medication administration. Procedure: 1Trilogy Health Services honors the resident's right to self determine their schedule and care choices and to maintain an environment and routine similar to their pattern prior to residing at the campus. 2. Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD - (every day) after the resident awakens in the morning (morning is designated as times between 4 AM and 10 AM)	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE
	PREFIX	Review of the "Purpose: guidelines for medication as Procedure: 1Trilogy honors the result determinant and care chomaintain and routine similar prior to reside 2. Unless as designated by physician medication and care chomaintain and routine similar prior to reside 2. Unless as designated by physician medications: a. QD - (every resident away morning (modesignated and and and and and and and and and an	ry day) after the kens in the orning is stimes between 4 AM)		PREFIX	reeducated on medication administration and prevention medication are recorded to the Appropriate will complete a competency medication administration. Sexhibit A and B attached How corrective action will be mon to ensure the deficient practic will not recur, i.e., what quality assurance program will be pinto place: Director of Health Services or designee will corrandom weekly medication administration observations. exhibit C. Audits will be submitted to the Auality Assurance committee month for 6 months. By what date the systemic changes will be	n of staff for See v the itored ce ty ut mduct See	COMPLETION
the morning and at bedtime 3. the nurse administering the		the morning	and at bedtime					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	LETED	
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS		STREET A	ADDRESS, CITY, STATE, ZIP CODE ATERFORD CIRCLE EN, IN46526		
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	medications	shall record the					
	time the med	diation was					
	administered along with his/her						
	initials.						
		e shall note the time					
	1	ous dose prior to					
	administerin	U					
	medication to ensure it is not						
	provided too close together"						
	#29 was revi 11:00 A.M. indicated Re diagnoses in not limited t history of bl						
	Intervention at 0900 (9:00 the resident's	n Error ee, Assessment and form, dated 5/4/11 0 A.M.), indicated s "medication o diff (different)					

011150

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155760	A. BUII	LDING	00	05/13/20	
		133700	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/13/20	, , , ,
NAME OF F	PROVIDER OR SUPPLIER				ATERFORD CIRCLE		
	AT WATERFORD (CROSSING HEALTH CAMPUS		1	EN, IN46526		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	nurses @ (at	t) two diff times"					
	The resident	's physician was					
	notified and						
	received to r						
	resident's blo						
	The Nurse's	Notes, dated					
	5/12/11, witl	h a late entry for					
	5/4/11 at 10	00 (10:00 A.M.),					
	indicated "M	fed (medication)					
		ed by day shift					
	•	am (a.m.) meds					
	· ·	0 mg, (milligrams)					
	` •	(suppository)					
		ng, norvase 5 mg,					
		mg, cymbalta 30					
	•	<u> </u>					
	•	10 mg, Losartan					
	*	5 mg, Zanaflex 2					
	0,	ven twice, night					
	shift nurse had given @ 0600 (6:00 a.m.), and day shift nurse checked all meds but looked at wrong date on MAR						
	(Medication	Administration					
	Record)"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE COMPL	
		155760	A. BUII B. WIN			05/13/2	011
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS		1332 W	ADDRESS, CITY, STATE, ZIP CODE VATERFORD CIRCLE EN, IN46526	ļ	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dated 5/2011 following: a Potassium 25 once a day (1 pressure), Za half tablet or spasms), Nortablet once a pressure), Cy tablet once a pressure), Cy capsule once (depression) one tablet on (dementia), I one tablet on tract infection suppository (inflammatical contract).	Aricept 10 mg ace a day Levaquin 500 mg ace a day (urinary an), and Anusol one twice a day					

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011150

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION 00		(X3) DATE : COMPL		
AND FLAIN	OI CORRECTION	155760	A. BUII		00		05/13/2	
			B. WIN		ADDRESS, CITY, STAT	E, ZIP CODE		
	PROVIDER OR SUPPLIER			1332 W	ATERFORD CIRC	•		
	AT WATERFORD C	CROSSING HEALTH CAMPUS		GOSHE	EN, IN46526			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLA (EACH CORRECTIVE	AN OF CORRECTION ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED DEFIC	O TO THE APPROPRIAT CIENCY)	E	DATE
	the medication	on errors that had						
	occurred on	5/4/11 at 0900						
	(9:00 A.M.),	UM #9 indicated						
	morning med	dications had been						
	given and sig	gned out by the						
	third shift N	urse LPN #15. The						
	UM indicate	d when the first						
	shift Nurse I	LPN #12 saw that						
	the resident	was awake, LPN						
	#12 checked	Resident # 29's						
	morning med	dications against						
	the Medicati	on Administration						
	Record (MA	R). The Unit						
	Manager #9	indicated LPN#						
	12 had not c	hecked to see if the						
	resident's me	edications were						
	already signe	ed out as given,						
	, ,	ndicated LPN #12						
	found the me	edication errors						
	after she gav	re the resident the						
	medications	and LPN #12 had						
	come back to	the MAR to sign						
	she had give	n the medications.						
	Unit Manage	er #9 indicated she						
	is unsure wh	y Resident #29 had						
EODW CMC 3	567(02-99) Previous Versio	ns Obsolete Event ID:	PERU11	Facility 1	ID: 011150	If continuation sh	neet D	ge 9 of 17

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	ILTIPLE CON	NSTRUCTION		(X3) DATE : COMPL	
AND LAN	OI CORRECTION	155760	A. BUIL		00		05/13/2	
			B. WINC	_	DDRESS, CITY, STATE	, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ATERFORD CIRC			
MAPLES	AT WATERFORD O	CROSSING HEALTH CAMPUS		GOSHE	N, IN46526			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN	N OF CORRECTION		(X5) COMPLETION
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED T DEFICIE	TO THE APPROPRIAT	E	DATE
	not stopped	and told Nurse #12						
	that she had	already had her						
	morning med	dications. UM #9						
	indicated the	e resident had a						
	decline in he	er condition and						
	was not as al	lert as she had been						
	previously.	UM #9 indicated						
	after the med	dication errors had						
	occurred, the	e Physician had						
	been contact	ted and Resident						
	#29's blood j	pressures were						
	monitored ar	nd remained above						
	90 systolic a	and 60 diastolic.						
		indicated LPN #12						
	should have							
		AR to see if the						
		had already been						
	given.	naa an eaay seen						
	51,011.							
	On 5/13/11 a	at 10:15 A.M., the						
		Nursing Services						
		nterviewed in						
	` ′	e medication error						
	_	nd indicated she						
	ŕ	ed LPN #12 after						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	PERU11	Facility II	D: 011150	If continuation sh	eet Pa	ge 10 of 17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		(X2) MU A. BUII B. WING	LDING	nstruction 00	(X3) DATE : COMPL 05/13/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE		
		CROSSING HEALTH CAMPUS		1	ATERFORD CIRCLE :N, IN46526		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		on errors had					
	occurred.						
	On 5/13/11 a Employee F was reviewed date of hire #12 had bee medication a On 5/13/11 a #12 was inte to Resident a error and ince checked the with the MA looked at the she had not	_					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155760	B. WIN	3 <u> </u>		05/13/2	011
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS	•	1332 WA	DDRESS, CITY, STATE, ZIP CODE ATERFORD CIRCLE N, IN46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED R DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0514 SS=D	each resident in according record information to identhe resident's assess and services provipreadmission scresstate; and progress Based on recording facility failed to were accurate correct Cardio Resuscitation (documented on Care Assignment #27) The facility ensure document relication assessment relication (assessment relication facility failed to the facility failed facility failed to the facility failed facility failed to the facility failed faci	ord review, ad interviews, the to assure records in regard to the pulmonary (CPR) code status in the Resident First ent form. (Resident ity also failed to entation of ated to the use of complete. (Residents this deficiency 14 residents whose us was reviewed and s with indwelling	F0	514	It is the expectation of this far to maintain clinical records or each resident in accordance accepted professional standard and practices that are comples accurately documented; read accessible; and systematical organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the of care and services provided results of any preadmission screening conducted by the State; and progress notes. We corrective action will be accomplished for those resident the deficient practice: Resident#27 CPR code was verified with the resident and physician. Resident First Ca guides and resident medical record was updated to reflect code CPR status. Resident and had catheter assessment	n with with ards ete; lilly blan d; the hat ents by	06/12/2011

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Event ID: PERU11 Facility ID: 011150

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155760		A. BUI	A. BUILDING 00		COMPL	x3) DATE SURVEY COMPLETED 05/13/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	011		
NAME OF PROVIDER OR SUPPLIER				1332 WATERFORD CIRCLE					
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				GOSHE	EN, IN46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			
(X4) ID PREFIX TAG	Findings inclu Resident #27 A.M., indicate admitted on 1 diagnosis whi not limited to depression. Prior to the in 5/9/11 at 11:4 Manager #9 provided a assignment fo at 11:00 A.M. Resident #27's CPR (cardiopresuscitation). The CPR constheresident's resident's resident's Powdated 7/21/20 was to be perfective.	the clinical record of on 5/10/11 at 10:00 ed Resident #27 was 0/27/10, with ch included, but were dementia and itial resident tour on 0 A.M., Unit Resident First rm, updated on 5/9/11, that indicated is code status as full ulmonary sent form signed by son, who was the ver of Attorney, and 10, indicated no CPR formed.		PREFIX	completed and indwelling for catheter use was found to be necessary due to the preser a stage four (4) pressure uld located on the coccyx to precontamination and impede healing to the wound. Care was updated. Resident #36 catheter assessment completed and assessment was review with resident and physician. Physician dictated a diagnos "Neurogenic Bladder". Care updated. How other resident having the potential to be affor the same deficient practic be identified and what correaction will be taken: An audit resident Advance Directives Resident First Care guides were identified. An audit of residents with foley catheter completed and no deficit practices were found. What measures will be put into play what systemic changes will made to ensure that the defipractice does not recur: The facility reviewed its policy regarding assessments and found it to be sufficient. Resadmitted will have their medichart audited within the first seventy-two (72) hours of admission, and quarterly, by	ley e nce of er vent plan had eted eted sis of plan s fected ce will ctive t of and vas ctices nts s was ace or be cient eted idents ical	(X5) COMPLETION DATE		
	The Physician's Order Sheet dated				Director of Health Services, designee, to assure that				
	ŕ	ited the Advanced			compliance in regards to car usage is met. Advance Dire				
	Directives we	re documented that			will be reviewed upon admis				

A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN46526 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DATE OD (COMPLETED OD	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN46526 (X5) PROVIDERS PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760			A. BUILDI	NG	00	COMPLETED	
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL (EACH DEFICIENCED DEFICIENCY MUST BE PERCEDED BY FULL (EACH DEFICIENCED DEFICIENCY MUST BE PERCEDED BY FULL (EACH DEFICIENCED TO THE APPROPRIATE (X5) COMPLETION						05/13/2	U11	
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	NAME OF PROVIDER OR SUPPLIER							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	MADI ES AT WATEREORD CROSSING HEALTH CAMPLIS							
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION						N, 11440020		
CROSS-REFERENCED TO THE APPROPRIATE				1				
		`			- 1	CROSS-REFERENCED TO THE APPROPRIATE		
Resident #27's code status was no confirmed with resident and			·					
physician, and updates to the			s code status was no					
Tresident i list Care guides within		CPK.				•		
the first seventy-two (72) hours of admission. To begin immediately								
On 5/12/11 at 10:00 A.M., the		On 5/12/11 at	10:00 A.M., the				itoly	
Director of Nursing Service (DNS) corrective action will be monitored		Director of Nu	rsing Service (DNS)		corrective action will be mor			
was interviewed in regard to the to ensure the deficient practice will not recur, i.e., what quality		was interview	ed in regard to the					
resident's code status and the DNS assurance program will be put			<u> </u>			•		
indicated Resident #27 was to be a into place: The DHS will report						into place:The DHS will report	rt	
monthly to the Quality Assurance		no CPR code status. The DNS				-		
						Committee on outcomes of the reviews for the next 6 months,		
and thereafter as determined by		indicated that CNA #11 who was responsible for typing the Resident First assignment form was unsure why the code status was typed incorrectly.				·		
ino quanty resources						•		
This assignment form was ansare						Committee. The DHS is responsible for substantial		
why the code status was typed complianceBy what date the						•		
completed: June 12, 2011						completed: June 12, 2011		
2. On 5/9/10 at 11:A.M., during the		2. On 5/9/10 a	t 11·A M during the					
		entrance tour, accompanied by the Unit Manager #9, Resident #52 was observed to have an indwelling catheter in place. The unit director of the 300 hall indicated the catheter was required to prevent contamination to the resident's						
of the 300 hall indicated the								
catheter was required to prevent								
sacral ulcer.								
The clinical record of Regident #52		The clinical ra	poord of Posidont #52					
		The clinical record of Resident #52						
was reviewed on 5/10/11 at 10:15								
A.M., and indicated an admission		A.M., and ind	icated an admission					
date of 9/27/10, and diagnoses		date of 9/27/10	0, and diagnoses					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760		· ·		ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPL	
			A. BUILDING B. WING			05/13/2011	
NAME OF PROVIDER OR GUIDNIER			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	ATERFORD CIRCLE		
MAPLES	MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			GOSHE	EN, IN46526		_
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	which included but were not limited						
	to malnutrition and sacral ulcer.						
	The resident h	ad been attending					
	the wound clir	nic and a wound vac					
	had been in pla	ace on admission.					
	The resident n	o longer attended the					
	wound clinic a	and the wound vac					
	had been disco	ontinued.					
	There was no catheter assessment						
	form in the clinical record and						
	during interview on 5/10/11 at 2:00						
	P.M., the unit director indicated she						
	was unsure why the catheter						
	assessment form had not been completed.						
		at 11:10 A.M., during					
	the entrance tour, accompanied by the Unit Manager #9, Resident #36 was observed to have a catheter in place. At this time the Unit						
	Manager indic	ated the resident was					
		pice care and the					
	catheter was re	equired due to urinary					
	retention.						
		cord of Resident #36					
	was reviewed	on 5/10/11 at 3:00					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155760		B. WING 05/13/2011)11		
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE	•		
MADI EC AT WATEREARD OROCCING LIEALTH CAMPLIC				1	ATERFORD CIRCLE			
	S AT WATERFORD CROSSING HEALTH CAMPUS			GOSHEN, IN46526				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	P.M., and indicated diagnoses							
	, and the second	d but were not limited						
	to atrial fibrilla	ation and history of						
		vascular accident-						
	stroke).							
	ŕ							
	A significant c	change MDS						
	(minimum dat	a set) assessment,						
	dated 3/2/11, indicated an							
	indwelling catheter was in place.							
	The catheter assessment form,							
	dated 5/4/11, indicated the reason							
	for the catheter was retention.							
	There was an area on the form which indicated supporting							
	information fo							
	insertion should be assured. Review of the record did not indicate supporting documentation. During interview on 5/11/11 at 3:15 P.M., the DNS indicated the resident was to have a consultation							
	with a urologis	St.						
	3.1-50(a)(1) 3.1-50(a)(2)							
			_					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155760			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		B. WING 05/13/2011						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WATER FORD OF DROLLE								
		CROSSING HEALTH CAMPUS	GOSHE	/ATERFORD CIRCLE EN, IN46526				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			
			1					